

		FOR OHF USE				

LL 1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0026955</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Washington Christian Village</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>July 1, 2003</u> to <u>June 30, 2004</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>1110 New Castle Road</u> <u>Washington</u> <u>61571</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Tazwell</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____	
Telephone Number: <u>309-444-3161</u> Fax # () _____		(Type or Print Name) <u>Richard A. Walbert</u>	
IDPA ID Number: <u>37-0841562006</u>		(Title) <u>Vice President of Finance</u>	
Date of Initial License for Current Owners: <u>04/01/1982</u>		(Signed) _____ (Date) _____	
Type of Ownership:		Paid Preparer (Print Name and Title) <u>William O. Buskirk</u> <u>CPA</u>	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT		(Firm Name & Address) <u>Eck, Schafer & Punke, LLP</u> <u>600 East Adams Springfield, IL 62701-1624</u>	
<input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust		(Telephone) <u>217-525-1111</u> Fax # <u>217-525-1120</u>	
IRS Exemption Code <u>501c3</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____			
<input type="checkbox"/> GOVERNMENTAL			
<input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>William O. Buskirk</u> Telephone Number: <u>217-525-1111</u>			

Facility Name & ID Number Washington Christian Village# 0026955 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>122</u>	Skilled (SNF)	<u>122</u>	<u>44,530</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>122</u>	TOTALS	<u>122</u>	<u>44,530</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>19,862</u>	<u>5,375</u>	<u>3,052</u>	<u>28,289</u>	8
9	SNF/PED					9
10	ICF	<u>9,467</u>	<u>2,987</u>		<u>12,454</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>29,329</u>	<u>8,362</u>	<u>3,052</u>	<u>40,743</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.50%

D. How many bed-hold days during this year were paid by Public Aid?

364 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 04/01/1982

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 04/01/1982 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 21 and days of care provided 3,052Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/2004 Fiscal Year: 06/30/2004

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Washington Christian Village

0026955

Report Period Beginning: July 1, 2003

Ending: June 30, 2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	194,556	14,285	7,010	215,851		215,851		215,851		1
2	Food Purchase		202,112		202,112		202,112	(165)	201,947		2
3	Housekeeping	159,348	23,868		183,216		183,216		183,216		3
4	Laundry										4
5	Heat and Other Utilities			112,217	112,217		112,217	9,744	121,961		5
6	Maintenance	59,452	18,498	21,965	99,915		99,915	10,589	110,504		6
7	Other (specify):*										7
8	TOTAL General Services	413,356	258,763	141,192	813,311		813,311	20,168	833,479		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,859,878	223,559	9,864	2,093,301		2,093,301		2,093,301		10
10a	Therapy			281,323	281,323		281,323		281,323		10a
11	Activities	30,740			30,740		30,740	31	30,771		11
12	Social Services	87,656	2,301	3,070	93,027		93,027		93,027		12
13	Nurse Aide Training										13
14	Program Transportation			4,046	4,046		4,046	(4,046)			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,978,274	225,860	305,503	2,509,637		2,509,637	(4,015)	2,505,622		16
	C. General Administration										
17	Administrative	72,402	288	291,896	364,586		364,586	(200,305)	164,281		17
18	Directors Fees										18
19	Professional Services			11,228	11,228		11,228	8,606	19,834		19
20	Dues, Fees, Subscriptions & Promotions			23,877	23,877		23,877	(2,408)	21,469		20
21	Clerical & General Office Expenses	107,199	4,876	72,679	184,754		184,754	50,034	234,788		21
22	Employee Benefits & Payroll Taxes			456,818	456,818		456,818	27,996	484,814		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,875	5,875		5,875	11,741	17,616		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			109,373	109,373		109,373	1,136	110,509		26
27	Other (specify):*										27
28	TOTAL General Administration	179,601	5,164	971,746	1,156,511		1,156,511	(103,200)	1,053,311		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,571,231	489,787	1,418,441	4,479,459		4,479,459	(87,047)	4,392,412		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Washington Christian Village

#0026955

Report Period Beginning: July 1, 2003 Ending:

June 30, 2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			143,834	143,834		143,834	17,107	160,941			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			367,069	367,069		367,069	(1,838)	365,231			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Deferred Bond Cost			1,167	1,167		1,167		1,167			36
37	TOTAL Ownership			512,070	512,070		512,070	15,269	527,339			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			15,097	15,097		15,097		15,097			39
40	Barber and Beauty Shops	16,957	723		17,680		17,680		17,680			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,978	66,978		66,978		66,978			42
43	Other (specify):* Apt/Cong			132,502	132,502		132,502	(13,895)	118,607			43
44	TOTAL Special Cost Centers	16,957	723	214,577	232,257		232,257	(13,895)	218,362			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,588,188	490,510	2,145,088	5,223,786		5,223,786	(85,673)	5,138,113			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Washington Christian Village

0026955

Report Period Beginning:

July 1, 2003

Ending:

June 30, 2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(867)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4,765)	32		10
11	Discounts, Allowances, Rebates & Refunds	135	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(13,895)	43		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,639)	21		24
25	Fund Raising, Advertising and Promotional	(2,408)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	(11,448)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (65,887)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(19,786)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (19,786)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (85,673)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Washington Christian Village

ID# 0026955

Report Period Beginning: July 1, 2003

Ending: June 30, 2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous	\$ (1,405)	17	1
2	Vending	702	2	2
3	Activity	31	11	3
4	Exempt Interest Income - Endowment	2,927	32	4
5	Marketing	(9,657)	21	5
6	Transportation	(4,046)	14	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(11,448)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington Christian Village

0026955

Report Period Beginning:

July 1, 2003

Ending:

June 30, 2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(165)	0	0	0	0	0	0	0	0	0	0	(165)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	9,744	0	0	0	0	0	0	0	0	0	9,744	5
6	Maintenance	0	10,589	0	0	0	0	0	0	0	0	0	10,589	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(165)	20,333	0	0	0	0	0	0	0	0	0	20,168	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	31	0	0	0	0	0	0	0	0	0	0	31	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(4,046)	0	0	0	0	0	0	0	0	0	0	(4,046)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(4,015)	0	0	0	0	0	0	0	0	0	0	(4,015)	16
	C. General Administration													
17	Administrative	(1,405)	(198,900)	0	0	0	0	0	0	0	0	0	(200,305)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,606	0	0	0	0	0	0	0	0	0	8,606	19
20	Fees, Subscriptions & Promotions	(2,408)	0	0	0	0	0	0	0	0	0	0	(2,408)	20
21	Clerical & General Office Expenses	(42,161)	92,195	0	0	0	0	0	0	0	0	0	50,034	21
22	Employee Benefits & Payroll Taxes	0	27,996	0	0	0	0	0	0	0	0	0	27,996	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	11,741	0	0	0	0	0	0	0	0	0	11,741	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,136	0	0	0	0	0	0	0	0	0	1,136	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(45,974)	(57,226)	0	0	0	0	0	0	0	0	0	(103,200)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(50,154)	(36,893)	0	0	0	0	0	0	0	0	0	(87,047)	29

Facility Name & ID Number Washington Christian Village

0026955

Report Period Beginning: July 1, 2003 Ending: June 30, 2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Utilities	\$	Christian Homes, Inc	100.00%	\$ 9,744	\$ 9,744	1
2	V	6 Maintenance				10,589	10,589	2
3	V	17 Administration	270,756			71,856	(198,900)	3
4	V	19 Professional Services				8,606	8,606	4
5	V	21 Clerical				92,195	92,195	5
6	V	22 Employee Benefits				27,996	27,996	6
7	V	24 Travel & Seminar				11,741	11,741	7
8	V	26 Insurance				1,136	1,136	8
9	V	30 Depreciation				17,107	17,107	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 270,756			\$ 250,970	\$ * (19,786)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	This workpaper is not applicable.					Hours	Percent	Description	Amount		1
2									\$		2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2003 Ending: ne 30, 2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	This workpaper is not applicable.				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	Revenue Bond 2001-Y (92%)	x		Refinance Debt	\$13,416.00	10/01/01	\$ 2,301,544	\$ 2,301,544	10/01/31	0.0700	\$ 161,105	1							
2												2							
3	Tax Exempt Bonds		x	Bldg & Equipment	\$6,883.33	09/01/91	1,000,000	560,000	09/01/11	0.0600	35,052	3							
4	Revenue Bond 1996-A	x		Redeem Debt	\$3,867.67	07/01/96	500,000	432,167	07/01/21	0.0700	30,558	4							
5	Revolving Loan Fund	x		Roof Work - Bldg	\$552.08	11/01/96		43,928	03/01/96	0.0200	940	5							
	Working Capital																		
6	CHI Bond Fund	x		Operations	\$5,000.00	Various	Various	814,642	09/01/19	0.0850	69,368	6							
7	Revenue Bond 1999-A	x		Redeem Debt	\$6,739.00	01/01/99	1,000,000	899,400	01/01/24	0.0700	63,542	7							
8	Financing fee amort										6,504	8							
9	TOTAL Facility Related					\$36,458.08		\$ 4,801,544	\$ 5,051,681			\$ 367,069	9						
	B. Non-Facility Related*																		
10	Revenue Bonds 2001-Y (8%)	x		Redeem Debt	\$1,167.00	10/01/01	198,456	198,456	10/01/31	0.0700	13,895	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related					\$1,167.00		\$ 198,456	\$ 198,456			\$ 13,895	14						
15	TOTALS (line 9+line14)							\$ 5,000,000	\$ 5,250,137			\$ 380,964	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

<div style="border: 1px solid black; padding: 2px;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>						\$	
1. Real Estate Tax accrual used on 2003 report.						\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)						\$	N/A
3. Under or (over) accrual (line 2 minus line 1).						\$	#VALUE!
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)						\$	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)						\$	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)						\$	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.						\$	#VALUE!
Real Estate Tax History:							
Real Estate Tax Bill for Calendar Year:		1999	_____	8		FOR OHF USE ONLY	
		2000	_____	9	13	FROM R. E. TAX STATEMENT FOR 2003	\$
		2001	_____	10	14	PLUS APPEAL COST FROM LINE 5	\$
		2002	_____	11	15	LESS REFUND FROM LINE 6	\$
		2003	_____	12	16	AMOUNT TO USE FOR RATE CALCULATION	\$

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington Christian Village COUNTY Tazwell

FACILITY IDPH LICENSE NUMBER 0026955

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>02-02-14-300-023</u>	<u>SEC 14 T26N R3W</u>	\$ <u>1,762.84</u>	\$ _____
2. <u>02-02-14-300-021</u>	<u>SEC 14 T26N R3W</u>	\$ <u>14,244.38</u>	\$ _____
3. <u>02-02-14-308-001</u>	<u>SEC 14 T26N R3W</u>	\$ <u>6,599.34</u>	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>22,606.56</u></u>	\$ <u><u> </u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,956 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apartments

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	38,484	1982	\$ 50,000	1
2	Home Office Allocation			7,403	2
3	TOTALS	38,484		\$ 57,403	3

Facility Name & ID Number Washington Christian Village

0026955

Report Period Beginning:

July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	122		1982		\$ 1,203,052	\$ 34,373	35	\$ 34,373		\$ 765,662	4
5											5
6											6
7											7
8	Home Office Allocation				58,896	1,707		1,707		28,677	8
9	Improvement Type**										
10	Blank										9
10	Office Door		1982		299	9	35	9		199	10
11	Blank										11
12	A/C Compressor		1982		1,200		5			1,200	12
13	Improvements		1982		13,562	387	35	387		8,321	13
14	Improvements		1983		34,486	985	35	985		20,931	14
15	Sprinkler System		1983		1,806	72	25	72		1,536	15
16	A/C Condensors		1983		4,775	14	20	14		4,775	16
17	Boiler		1983		8,332	97	20	97		8,332	17
18	Water Heater		1983		321		15			321	18
19	Sign		1984		2,800		12			2,800	19
20	Door		1984		231	7	20	7		142	20
21	Nurse Call System		1984		2,930		15			2,930	21
22	Alarm System		1984		786	39	20	39		770	22
23	Remodeling		1985		18,956	542	35	542		10,569	23
24	Tub Room		1985		1,230		15			1,230	24
25	Insulation		1985		4,890	245	20	245		4,635	25
26	Light Fixtures		1985		425		10			425	26
27	Ceiling Tile		1985		323	16	20	16		304	27
28	Roof repairs		1985		342,609	9,789	35	9,789		190,885	28
29	Fire door		1986		400	20	20	20		368	29
30	Insulation		1986		4,203	210	20	210		3,710	30
31	Blank										31
32	Decorations		1988		342		5			342	32
33	Wall coverings		1988		356		5			356	33
34	Improvements		1988		3,706	106	35	106		1,723	34
35	Duct Work		1988		313		10			313	35
36	Painting(Remodeling)		1988		886		5			886	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Wallpaper	1988	\$ 910	\$	5	\$	\$	\$ 910	37
38	Nurse Call System	1989	8,534	426	15	426		8,534	38
39	22 Overbed lights	1989	1,579		10			1,579	39
40	Bath station	1989	558	34	15	34		558	40
41	Floor coverings	1990	1,765		5			1,765	41
42	Relay Stone and Tuckwork	1991	2,395	120	20	120		1,590	42
43	Blank								43
44	Water Heater	1991	1,223		10			1,223	44
45	Gutter & Soffit	1992	9,161	611	15	611		7,332	45
46	Water Heater	1993	1,134		10			1,134	46
47	Boiler	1993	11,405	760	15	760		8,043	47
48	Fire System-Horn/Strobe	1994	1,560	104	10	104		1,560	48
49	Water Heater	1994	890	67	10	67		890	49
50	Main/Store Room Doors	1994	1,730	173	10	173		1,701	50
51	Electrical Outlets	1994	813	81	10	81		796	51
52	HW Enthalpy Controls	1994	1,097		5			1,097	52
53	Doors	1995	3,368	337	10	337		3,173	53
54	Cabinets SFF Dining	1995	2,189	146	15	146		1,338	54
55	Hot H2O Lines/Rerout	1995	7,345		5			7,345	55
56	Rubber Adhered Roof	1996	62,678	3,134	20	3,134		26,378	56
57	BTC 200 Water Heater	1996	2,384	238	10	238		2,003	57
58	Kitchen Door	1996	622	62	10	62		517	58
59	Exhaust Fan/Light	1996	918	92	10	92		744	59
60	Add 4 baseboard heaters	1996	1,100	110	10	110		853	60
61	Wallpaper	1996	2,417		5			2,417	61
62	Remodel foyer area	1996	17,101	1,710	10	1,710		12,967	62
63	Carpeting - Front Entry	1997	974		5			974	63
64	Roof Work - North Wing	1997	32,480	2,165	15	2,165		14,433	64
65	IDPH Construction Project fee	1997	910	91	10	91		455	65
66	Wallpaper SW alcove	1998	1,030		5			1,030	66
67	Replace cove base	1999	2,009	201	10	201		1,189	67
68	100 gal. Gas water heater	1999	2,358	236	10	236		1,377	68
69	Kitchen fire suppression system	1999	1,307	131	10	131		731	69
70	TOTAL (lines 4 thru 69)		\$ 1,898,059	\$ 59,647		\$ 59,647	\$	\$ 1,178,978	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward		\$ 1,898,059	\$ 59,647		\$ 59,647		\$ 1,178,978		1
2	Wallpaper office conference room	1999	2,148	356	5	356		2,148		2
3	Condensing unit	1999	875	88	10	88		447		3
4	Wallpaper office alcove	1999	1,894	346	5	346		1,894		4
5	Carpeting offices	1999	3,510	644	5	644		3,510		5
6	Chaplain's Office A/C Unit	2000	875	88	10	88		396		6
7	Smoke Detectors (3)	2000	544	54	10	54		266		7
8	Boiler	2000	5,250	263	20	263		1,074		8
9	Automatic Opener Front Doors	2000	5,204	520	10	520		1,907		9
10	Airphone Emergency Phone System	2001	2,005	201	10	201		687		10
11	Remodeling South Wing	2001	47,029	3,135	15	3,135		10,189		11
12	Carpet E/W Corridors & Volunteer Ofc	10/1/2001	2,419	484	5	484		1,331		12
13	Remodeling South Wing	9/1/2001	1,755	117	15	117		332		13
14	Upgrades to Boiler System	11/1/2001	19,857	1,986	10	1,986		5,296		14
15	(3) Steel Doors	12/24/2001	1,371	137	10	137		354		15
16	Modular Nurses Station	5/24/2002	4,744	474	10	474		1,027		16
17	Opto 22 - Heating/AC Control System	1/8/2002	15,227	761	20	761		1,903		17
18	Architects Fees/Remodeling of Building	6/1/2002	11,383	759	15	759		1,581		18
19	Remodeling	4/30/2002	93,076	6,205	15	6,205		13,961		19
20	Remodel Front Entrance	4/24/2002	840	56	15	56		126		20
21	Remodel North Corridor/Wall Coverings	5/1/2002	66,545	13,309	5	13,309		28,836		21
22	Remodel North Corridor/Carpet	4/30/2002	27,270	5,454	5	5,454		12,272		22
23	Remodel North Corridor/Cove Base Hand Rail	4/30/2002	20,507	1,367	15	1,367		3,076		23
24	Replace A/C in Lobby	4/25/2002	2,276	228	10	228		513		24
25	Carpet/New Offices Near Lunch Room	5/1/2002	560	112	5	112		243		25
26	Corridor Door	4/30/2002	743	74	10	74		167		26
27	Remodel New Offices Near Lunch Room	5/1/2002	1,319	132	10	132		286		27
28	Carpet/Kitchen, Storage Rm, Back Ofc & H	6/21/2002	6,262	1,252	5	1,252		2,608		28
29	100 Gallon AO Smith Water Heater	7/17/2002	3,600	360	10	360		720		29
30	Remodeling - Offices	3/1/2003	8,522	852	10	852		1,136		30
31	Remodel Employee Break Room	3/1/2003	2,118	424	5	424		552		31
32	Architects Fees/Building Front	3/1/2003	319	21	15	21		28		32
33	Remodel Front Entrance	8/8/2003	34,300	2,096	15	2,096		2,096		33
34	TOTAL (lines 1 thru 33)		\$ 2,292,406	\$ 102,002		\$ 102,002		\$ 1,279,940		34

**Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Page 12C

Facility Name & ID Number Washington Christian Village

0026955

Report Period Beginning:

July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,292,406	\$ 102,002		\$ 102,002	\$	\$ 1,279,940	1
2	Tile Floors-Rms 154 & 174 Central Hall etc	9/13/2003	882	147	5	147		147	2
3	Repipe Boiler System	10/8/2003	2,581	194	10	194		194	3
4	Replace Tubes & Tube Sheets/Boiler	11/6/2003	6,950	927	5	927		927	4
5	Roof Repairs	11/13/2003	2,758	368	5	368		368	5
6	Fabricate/Install Piping - O2 Room	1/22/2004	580	58	5	58		58	6
7	(2) Auto Door Closers	1/29/2004	527	53	5	53		53	7
8	Move/Add Smoke Detectors	2/17/2004	3,503	146	10	146		146	8
9	Project Review Fee	2/29/2004	2,400		10				9
10	Remodel SW Alcove	5/17/2004	909	15	10	15		15	10
11	A/C Compressor - Activity Dept	6/11/2004	1,462	41	3	41		41	11
12	Outside shelter	2/20/1996	5,349	535	10	535		4,503	12
13	16 x 18 shed	11/7/1997	2,520	252	10	252		1,680	13
14	Fully depreciated land improvements	4/1/1982	43,675		15			43,675	14
15	Sewer	2/26/1988	987	49	20	49		804	15
16	Blacktop	8/25/1988	7,275	40	15	40		7,275	16
17	Resurface parking	6/30/1993	10,785		10			10,785	17
18	Sidewalk, west	10/22/1996	950	95	10	95		736	18
19	Landscaping front	5/6/2002	11,053	1,105	10	1,105		3,295	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,397,552	\$ 106,027		\$ 106,027	\$	\$ 1,354,642	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 328,190	\$ 38,728	\$ 38,728	\$	Various	\$ 172,914	71
72	Current Year Purchases	19,693	786	786		Various	786	72
73	Fully Depreciated Assets	200,613				Various	200,613	73
74	Home Office Allocation	94,654	12,602	12,602			42,754	74
75	TOTALS	\$ 643,150	\$ 52,116	\$ 52,116	\$		\$ 417,067	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1995 Ford Bus	1995	\$ 44,381	\$	\$	\$	8	\$ 44,381	76
77										77
78										78
79	Home Office Allocation			11,486	2,798	2,798			7,003	79
80	TOTALS			\$ 55,867	\$ 2,798	\$ 2,798	\$		\$ 51,384	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,153,972	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 160,941	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 160,941	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,823,093	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	\$ 120,656	\$	\$	86
87	Land Improvements	8,903	1,390	6,748	87
88	Buildings & Equipment	667,120	24,419	411,243	88
89					89
90					90
91	TOTALS	\$ 796,679	\$ 25,809	\$ 417,991	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$

13. /2006 \$

14. /2007 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	This workpaper is not applicable.	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 349,350	\$	1
2	Cash-Patient Deposits	9,789		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 41,988)	250,333		3
4	Supply Inventory (priced at FIFO)	19,134		4
5	Short-Term Investments	2,893		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest/Other A/R</u>	823		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 632,322	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	170,656		13
14	Buildings, at Historical Cost	2,910,202		14
15	Leasehold Improvements, at Historical Cost	83,628		15
16	Equipment, at Historical Cost	613,721		16
17	Accumulated Depreciation (book methods)	(2,162,650)		17
18	Deferred Charges	8,361		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	117,611		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,741,529	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,373,851	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 86,689	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,789		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	241,617		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,606		32
33	Accrued Interest Payable	2,800		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 363,501	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	43,928		39
40	Mortgage Payable			40
41	Bonds Payable	5,206,209		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Apt Income</u>	80,274		43
44	<u>Apt/Cong Life Right & Security Dp</u>	77,247		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,407,658	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,771,159	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (3,397,308)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,373,851	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,238,007)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,238,007)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(350,301)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (350,301)	17
	B. Transfers (Itemize):		
18	Transfer In from Affiliate	191,000	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 191,000	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,397,308)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,409,489	1
2	Discounts and Allowances for all Levels	(2,338,916)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,070,573	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	512,630	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 512,630	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	31,387	13
14	Non-Patient Meals	867	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,627	19
20	Radiology and X-Ray	11,478	20
21	Other Medical Services	808	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 58,167	23
	D. Non-Operating Revenue		
24	Contributions	36,447	24
25	Interest and Other Investment Income***	4,765	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 41,212	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized G(L) on Investments/Equipment Disposal	(5,198)	28
28a	Apt/Cong	196,101	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 190,903	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,873,485	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	813,311	31
32	Health Care	2,509,637	32
33	General Administration	1,156,511	33
	B. Capital Expense		
34	Ownership	512,070	34
	C. Ancillary Expense		
35	Special Cost Centers	165,279	35
36	Provider Participation Fee	66,978	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,223,786	40
41	Income before Income Taxes (line 30 minus line 40)**	(350,301)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (350,301)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Washington Christian Village

0026955

Report Period Beginning: July 1, 2003

Ending:

June 30, 2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,763	1,867	\$ 48,268	\$ 25.85	1
2	Assistant Director of Nursing	1,759	1,846	42,052	22.78	2
3	Registered Nurses	12,255	12,933	324,975	25.13	3
4	Licensed Practical Nurses	16,140	17,680	373,409	21.12	4
5	Nurse Aides & Orderlies	78,868	81,223	1,051,840	12.95	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,605	1,653	19,334	11.70	8
9	Activity Director	1,698	1,724	19,264	11.17	9
10	Activity Assistants	1,178	1,194	11,476	9.61	10
11	Social Service Workers	6,336	6,457	87,656	13.58	11
12	Dietician					12
13	Food Service Supervisor	1,675	1,720	23,432	13.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,920	18,250	171,124	9.38	15
16	Dishwashers					16
17	Maintenance Workers	4,520	4,550	59,452	13.07	17
18	Housekeepers	16,310	16,827	159,348	9.47	18
19	Laundry					19
20	Administrator	1,762	2,067	72,402	35.03	20
21	Assistant Administrator					21
22	Other Administrative	1,688	1,765	48,994	27.76	22
23	Office Manager	1,560	1,603	28,076	17.51	23
24	Clerical	2,170	2,217	30,129	13.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	1,258	1,282	16,957	13.23	33
34	TOTAL (lines 1 - 33)	170,465	176,858	\$ 2,588,188 *	\$ 14.63	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	170	\$ 7,010	1.3	35
36	Medical Director	72	7,200	9.3	36
37	Medical Records Consultant	60	4,320	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	3,110	10.3	39
40	Physical Therapy Consultant	2,188	126,563	10A.3	40
41	Occupational Therapy Consultant	1,700	100,520	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	967	54,240	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	52	2,845	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	5,305	\$ 305,808		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount		
Jodi Nylin	Administrator	0	\$ 72,402	Workers' Compensation Insurance		\$ 91,728	IDPH License Fee		\$ 2,220		
				Unemployment Compensation Insurance		9,000	Advertising: Employee Recruitment		3,967		
				FICA Taxes		193,071	Health Care Worker Background Check (Indicate # of checks performed _____)				
				Employee Health Insurance		146,400	Software Updates & Support		7,729		
				Employee Meals			Online, Remote & Media Fees		103		
				Illinois Municipal Retirement Fund (IMRF)*			Life Services Network dues		6,182		
				Employee Expense		11,412	Dues & Subscriptions		1,233		
				Employee Physicals		5,207	Miscellaneous Fees		35		
							Less: Public Relations Expense		(
							Non-allowable advertising		(
							Yellow page advertising		(
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$	72,402	TOTAL (agree to Schedule V, line 22, col.8)		\$	484,814		
B. Administrative - Other						E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount			
Management Expense			\$ 270,756	Home Office Allocation		27,996	Out-of-State Travel	\$ 0			
Other administrative expenses			21,140								
							In-State Travel	3,948			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							Miscellaneous	127			
C. Professional Services							Seminar Expense	1,800			
Vendor/Payee	Type		Amount				Home Office Allocation	11,741			
Van Ostrand	Legal		\$ 4,205				Entertainment Expense	(
Davis & Campbell	Legal		3,806				(agree to Sch. V, line 24, col. 8)				
Method Management	Consulting		3,217				TOTAL	\$ 17,616			
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				\$	11,228	TOTAL		\$			

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Washington Christian Village

STATE OF ILLINOIS

0026955

Report Period Beginning: July 1, 2003

Page 23

Ending: June 30, 2004

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network - \$ 6182
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,598 Line 3.10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 66,978
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 867
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Eck, Schafer & Punke, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. It will be provided upon completion.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Washington Christian Village
Allocation on Benefits

6/30/2004

kdb
10/21/04

Payroll Tax	Unemploy Contrib	Worker's Comp	Health Ins	W C Medical Exp	Employee Uniform Allow	Employee Expense	Employee Physicals	
13,615.98	444.00	4,560.00	8,800.00		(5.00)	11,416.22	5,207.00	44,038.20
4,016.72	228.00	2,340.00	10,800.00					17,384.72
14,631.44	972.00	9,948.00	10,800.00					36,351.44
11,744.16	816.00	8,280.00	100,800.00					121,640.16
139,192.32	5,988.00	60,972.00	15,200.00					221,352.32
8,570.30	480.00	4,884.00						13,934.30
1,300.47	72.00	744.00						2,116.47
193,071.39	9,000.00	91,728.00	146,400.00	0	(5.00)	11,416.22	5,207.00	456,817.61

Line 3.22.3 456,817.61

Washington Christian Village
Staffing and Salary Costs

			06/30/04		sms 11/03/05	
<u>Description</u>	<u>Line Number</u>	<u>Salary</u>	<u>% of Benefits</u>	<u>Benefits</u>	<u>Total Salary</u>	
Director of Nursing	20.1	46,413.39	2.60%	1,854.74	48,268.13	
Assist. DON	20.2	40,436.66	2.26%	1,615.90	42,052.56	
Registered Nurses	20.3	312,487.79	17.47%	12,487.41	324,975.20	
Licensed Practical Nurses	20.4	359,060.53	20.08%	14,348.51	373,409.04	
Nurses Aides & Orderlies	20.5	1,011,422.89	56.55%	40,417.74	1,051,840.63	
Rehab/Therapy Aides	20.8	18,591.00	1.04%	742.92	19,333.92	
Total		1,788,412.26	100.00%	71,467.22	1,859,879.48	
Benefits		71,467.22				
	<u>20.1</u>	<u>20.2</u>	<u>20.3</u>	<u>20.4</u>	<u>20.5</u>	<u>20.8</u>
	46,413.39	40,436.66	31,358.28	24,051.12	21,404.64	18,591.00
			12,517.57	157,978.66	22,003.40	
			149,512.25	138,174.69	45,688.01	
			77,001.52	11,890.74	556,646.37	
			37,043.77	22,998.23	209,674.67	
			1,544.02	387.55	60,196.67	
			3,510.38	3,579.54	6,984.75	
					12,898.74	
					2,177.61	
					1,878.15	
					71,869.88	
Totals	46,413.39	40,436.66	312,487.79	359,060.53	1,011,422.89	18,591.00